# MEMBER HANDBOOK


## L.A. Care Health Plan

*www.lacare.org*

&

## Community Health Plan

***www.ladhs.org/omc.com***

***Revision 18***



**Community Health Plan Member Services Department** toll-free **1-800-475-5550**
**L.A. Care Health Plan Member Services Department** toll-free **1-888-4LA-Care** or **1-888-452-2273**

# IN YOUR LANGUAGE

Dear *Member*,

We know that it is important to communicate clearly so you can get the *health care services* you need.

In the United States, there are laws, such as the Civil Rights Act of 1964, which protects you if you do not speak English. If you cannot hear or are hard of hearing (hearing impaired) or *disabled*, aged or blind, you are also protected by the Americans with Disabilities Act (ADA) of 1990. The ADA is a law that protects people with *disabilities* from discrimination. The ADA makes sure that there is equal opportunity for persons with *disabilities* in employment, state and local government services.

The doctor's office, clinic or *hospital* cannot deny services because you do not speak English, are hearing impaired, or have other *disabilities*. You have the right to free *interpreter* services when getting health care or any related service through your health plan. An interpreter is a person who translates orally what is said in one language to another language. This allows persons of different languages to speak with each other and understand each other.

*The meaning of italicized words are found in the "Glossary" Section at the end of this Member Handbook.*

*Please Note. This symbol means that there is important information.*

# The **Member Handbook** is also called the Combined Evidence of Coverage and Disclosure Form. The Member Handbook tells you how to get health care. It also has the terms and conditions of your health *benefits* coverage. You should read the Member Handbook completely and carefully.

If you or your child has special health needs, you should read the sections that apply to you.

This Member Handbook and the Summary of Benefits Section are only a summary of the **L.A. Care Health Plan (L.A. Care)** policies and rules. You must look at the contract between L.A. Care and the *State Department of Health Services (SDHS)* to determine the exact terms and conditions of coverage. Call **Community Health Plan** if you have questions about covered services or specific provisions. Call **L.A. Care** if you would like to request a copy of the contract.

## ☎ CONTACTS

### Community Health Plan

1000 South Fremont Avenue
Building A-9 East, 2nd Floor, Unit #4
Alhambra, CA 91803
1-800-475-5550
1-626-299-7259

### L.A. Care Health Plan

555 West Fifth Street, 18th Floor
Los Angeles, CA 90013
1-213- 623-8097(Fax)
Toll-free: 1-888-452-2273 or
1-888-4LA-Care

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# WELCOME TO L.A. Care Health Plan!

Thank you for **choosing L.A. Care Health Plan (L.A. Care) and Community Health Plan**. We will work hard to serve you and your family.

**L.A. Care** is a *Medi-Cal* pre-paid health insurance program or HMO. The state of California has given **L.A. Care** permission to serve you and to help you get quality *health care services*. The state of California pays for your health care and there is no cost to you.

Along with this Member Handbook you should have received a *provider directory*, and a **L.A. Care**/**Community Health Plan** identification (ID) card.

You may also get information on a particular provider in a geographical area of your choice by calling Community Health Plan.

## THE PLAN PARTNERS

**L. A. Care Health Plan's Plan Partners:**

- Blue Cross of California
- Care 1st Health Plan
- Community Health Plan
- Kaiser Permanente
- UHP Healthcare

**L.A. Care** works with the 5 health plans (Plan Partners) listed above to provide quality *health care services* for you. Each Plan Partner is a licensed health plan. **L.A. Care** is proud of its team of Plan Partners, doctors, nurses, *hospitals*, *pharmacists*, and staff.

As a *member* of **L.A. Care,** you have chosen or have been assigned to **Community Health Plan**. **Community Health Plan** will be responsible for all of your *health care services*.

# YOUR RIGHTS AND RESPONSIBILITIES

## Member Bill of Rights

### MEMBER RIGHTS

1. You have the right to have an appointment with your doctor within a reasonable time and have your doctor listen and work with you to take care of your health care needs.
2. You have the right to a confidential (private) relationship with your doctor. No one will talk about your health care unless you okay it.
3. You have the right to polite, kind and helpful care no matter what race, religion, sex, age, gender, cultural, or ethnic background.
4. You have the right to say no to medical treatment.
5. You have the right to know and understand your medical problem and treatment plan.
6. You have the right to get a copy of your medical records and have them kept private.
7. You have the right to get information and to be spoken to in the language that you understand and are comfortable with. This means that you can get free 24-hour interpreter services.
8. You have the right to file a grievance with Community Health Plan and/or L.A. Care if you do not receive your services in the language you request.
9. You have the right to get information on how to file appeals and *grievances* with **Community Health Plan,** directly to the state and L.A. Care. You also have a right to a State Fair Hearing.
10. You have the right to get preventive *health care services*
11. You have the right to a second opinion.
12. You have the right to get an answer to a request for *referrals*.
    - Routine or Regular – 5 business days
    - *Urgent*- 24 to 48 hours
    - *Emergency* – same day
13. You have the right to be informed when your doctor is no longer contracted with Community Health Plan and L.A. Care.

### MEMBER RESPONSIBILITIES

1. You are responsible for participating in your health care and the health care of your family. This means taking care of problems before they become serious. You should follow your doctor's instructions, take your medications, and participate in health programs that keep you well.
2. You are responsible for using the Emergency Room for emergencies only. Your *doctor* will provide most of the medical care you need.
3. You are responsible for being polite and helpful to people who give *health care services* to you and to your family.
4. You are responsible for making and keeping appointments for check-ups. Please call your doctor's office when you need to cancel.
5. You are responsible for participating in *Member* Satisfaction Surveys.

6. Your are responsible for reporting Health Care Fraud. You can report it without giving us your name. Call L.A. Care at toll free 1-800-400-4889.

## Confidentiality

You have the right to keep your medical records confidential. **You can request a copy of our confidentiality policy.** Just call **Community Health Plan** or **L.A**. Care. In particular, any results form genetic testing will not be disclosed.

# HOW TO USE L.A. Care Health Plan/ Community Health Plan Services

## Your Identification (ID) Card

Your **L.A. Care/Community Health Plan** ID card lets people know you are our *member*. Carry your **L.A. Care/Community Health Plan** ID card with you at all times. Show your **L.A. Care/Community Health Plan** ID card when you:

- Have a doctor's appointment,
- Go to the *hospital*,
- Pick up a *prescription*, or
- Get any other medical care.

## Your Beneficiary Identification Card (BIC)

You should also have a Beneficiary Identification Card (BIC) or *Medi-Cal* Card from the state of California. You may need to show that card to get certain services. Call the Department of Public and Social Services (DPSS), toll-free at 1-877-481-1044, if you have any questions or to get a new BIC card.

! **Never** let anyone use your **L.A. Care/Community Health Plan** ID card or your BIC Card. Letting someone else use your **L.A. Care/Community Health Plan** ID Card or BIC Card with your knowledge is fraud.

## Primary Care Physician (PCP)

A *Primary Care Physician (PCP)* is your personal doctor. He/she will make sure that you get all the health care you need. He/she will refer you to a specialist when needed. It is important that you choose a *PCP*, and visit your *PCP* regularly. As your *PCP* learns more about you and your health, he/she can provide you with better quality care.

## How To Choose a Primary Care Physician (PCP)

**Choose a *PCP* when you enroll.**
You were asked to choose a *PCP* and a Plan Partner when you completed the *enrollment* form. A *PCP* was chosen for you if you did not choose a *PCP* on your *enrollment* form. The choice was based on:

- The language you or your child speaks,
- How far you live from the *PCP's* office, and
- Specialty care most appropriate for a *member's* age.

You can choose any *PCP* from the **Community Health Plan** *provider directory*.

**Points to remember when choosing a *PCP*.**

- When you choose a *PCP* you are also choosing the specialists*, hospitals* and other health care *providers* within their *network*.
- Your *PCP* chooses from the *providers* within their *network* when referring you to needed services.
- You will be informed within 30 days of the date your *PCP* stops working with **Community Health Plan.**

**You may choose a different *PCP* for each *eligible* family member.** A *PCP* will be chosen for each family member, if one was not chosen.

## How to Change Your Primary Care Physician (PCP)

! To change *PCPs*, call **Community Health Plan**. **L.A. Care** cannot make *PCP* changes.

If you did not get the *PCP* you chose, call **Community Health Plan** to see if he/she is available. You can change your *PCP* at any time and for any reason if you are not happy with the assignment.

## Federally Qualified Health Centers (FQHCs)

As a *member* of **L.A. Care**/**Community Health Plan,** you have the right to receive your primary care at a FQHC that is contracted with **Community Health Plan**. FQHCs are health centers that receive money from the federal government. FQHCs are located in areas that do not have a lot of *health care services*. Call **Community Health Plan** for the names and addresses of the FQHCs that contract with **Community Health Plan**.

## How to Change Your Plan Partner

**STEP 1**: Call **L.A. Care**. **Community Health Plan** is not able to make Plan Partner Transfers.

**STEP 2:** A Member Services Representative will send you a Plan Partner Transfer Request Form and a return envelope.

**STEP 3:** Review and sign the form.

**STEP 4:** Return the form in the envelope **L.A. Care** sends to you before the 20th of the month.

If **L.A. Care** receives the form before the 20th of the month, the change will be effective the 1st of the next month. If **L.A. Care** receives the form after the 20th of the month, the change will be delayed by one month.

For example: if **L.A. Care** receives the form on January 3rd, the change will be effective February 1st. However, if **L.A. Care** receives the form on January 25th, the change will be effective March 1st.

You may also fill out a Plan Partner Transfer Request Form at **L.A. Care**. Call **L.A. Care** if you need directions.

## How to Get Health Care Services

### ➲ How To Get Routine Care

Regular health check-ups help you and your children stay healthy. Routine care is when you go to your *PCP* for a regular health check-up, even when you are not sick. To get a regular health check-up you need to call and make an appointment.

Examples of routine care include:

- Immunizations/shots
- Initial Health Assessment (first health check-up)
- Well-child exams

You need to make an appointment for your first health check-up as soon as possible if you are a new *member* of **L.A. Care/Community Health Plan**. This check-up will help you and your *PCP* know each other better. It will help him/her provide you with better care.

**SCHEDULING A DOCTOR'S APPOINTMENT**
Call your doctor's office.

Your *PCP's* phone number can be found on your ID card or in the *provider directory*. You should have received a copy of the *provider directory* with this Member Handbook. Call **Community Health Plan** if you need another copy.

**CANCELING OR RESCHEDULING A DOCTOR'S APPOINTMENT**
Please call and let your doctor know right away if you need to cancel an appointment. By canceling your appointment you allow someone else to be seen by the doctor. If you miss your appointment, call your doctor right away to reschedule.

## ➲ How To See A Specialist

Specialists are doctors who take care of special health problems. Specialists are doctors with training, knowledge, and practice in one area of medicine. For example, a cardiologist is a heart specialist and has years of special training to deal with heart problems.

If your *PCP* thinks it is *medically necessary* for you to see a specialist, your *PCP* will refer you.

**PRIOR AUTHORIZATIONS AND REFERRALS**
Your *PCP* must approve all *health care services* before you receive them. This is called prior *authorization*. A referral is when you request *health care services* that your *PCP* does not normally provide. Some services do not require a referral. Go to the "Summary of Benefits" Section on Pg.9 for a list of services.

Different types of referral request different timeframes:

- Routine or Regular – 5 business days
- Urgent – 24 to 48 hours

Please call **Community Health Plan** if you have not received a response within the above timeframes.

All *health care services* are reviewed, approved or denied according to *medical necessity*. If you would like a copy of the policies and procedures **Community Health Plan** uses to decide if a service is *medically necessary*, call **Community Health Plan.**

**REFERRALS TO NON-PHYSICIAN PROVIDERS**
You may get services from non-physician providers who work in your PCP's network. Non-physician providers may include, but not limited to Clinical Social Workers, Family Therapists, and Nurse Midwives. You may need a referral from your PCP to see these types of providers. For more information, ask your PCP, or call Community Health Plan.

## ➲ How To Get A Second Opinion

A second opinion is a visit with another doctor when:

- You question a *diagnosis*,
- You do not agree with your *PCP's* treatment plan, or
- You would like to make sure your treatment plan is right.

The second opinion must be from an *appropriately qualified healthcare professional* in your *network*. You have the right to ask for and to get a second opinion, and to ask for timelines for making routine and urgent opinions available.

**WHAT DO YOU NEED TO DO?**

**STEP 1**: Talk to your *PCP* or **Community Health Plan** and let him/her know that you would like to see another doctor and the reason why.

**STEP 2**: Your *PCP* or **Community Health Plan** will refer you to an *appropriately qualified healthcare professional r*

**STEP 3**: Call the second opinion doctor to make an appointment.

**If you do not agree with the second opinion,** you may file a *grievance* with **Community Health Plan**. Go to the "Grievances and Appeals" Section on Pg.17 for more information.

## ➲ How To Get A Standing Referral

If you have a *chronic life-threatening* or *disabling* condition or disease (such as HIV/AIDS), you may need to see a specialist or *appropriately qualified healthcare professional* for a long time. Your *PCP* may suggest you receive a standing referral or you may ask for a standing referral.

A standing referral needs *authorization*. Once you have a standing referral, you will not need *authorization* for each visit with the specialist or *appropriately qualified healthcare professional*. A standing referral is made to a specialist or *appropriately qualified healthcare professional* who is in your *network* or who is with a contracted specialty care center. For a list of *appropriately qualified healthcare professional ,* call **Community Health Plan**. Your specialist or *appropriately qualified healthcare professional* will develop a treatment plan for you if necessary. The treatment plan will show how often you need to go to the doctor. Once the treatment plan is approved, the specialist or *appropriately qualified healthcare professional* will be your coordinator of care, and be authorized to provide health care services the same way your *PCP* would, based on the area of expertise and training, according to the treatment plan.

## ➲ How To Keep Seeing Your Doctor If Your Doctor Has Left The Plan

You will be informed by mail 30 days before the date your doctor stops working with **Community Health Plan**. You can ask to keep seeing your doctor, if he/she agrees and has been treating you for any of the following conditions:

- *Acute* condition
- Serious *chronic* (long-term) condition

- Last six (6) months of pregnancy
- High-risk (difficult) pregnancies
- Delivery-related services

If you have an *acute* or serious *chronic* condition, you will continue to receive services from your provider for at least 90 days (or a longer period of time if necessary for a safe transfer). After the delivery of your baby you can continue to receive delivery related services from your provider until a safe transfer can be made to another doctor in your *network*. **Community Health Plan** will help to make this a safe transfer. Please call **Community Health Plan** if you have any questions.

## ➲ How To Get Urgent Care

Urgent care is when a condition, illness or injury is not *life-threatening*, but needs medical care right away. Many of **Community Health Plan's** doctors have urgent care hours in the evening and on weekends.

**For urgent care, follow these steps:**

**STEP 1**: Call your *PCP*.

Another doctor may answer your call if your *PCP* is not available. A doctor is available by phone 24 hours a day, 7 days a week.

**STEP 2**: Tell the person who answers the phone that you are a **L.A. Care/Community Health Plan** *member*.

**STEP 3**: Ask to speak to your *PCP* or the doctor on-call. Tell the doctor what has happened and follow his/her instructions.

Call **Community Health Plan** at anytime if you cannot contact your *PCP***.**

## ➲ How To Get Emergency Care

**Community Health Plan** covers medically necessary emergency care services 24 hours a day, seven (7) days a week. Emergency care is a service that a "*prudent lay person"* considers necessary to stop or relieve:

- Serious illnesses or symptoms
- Injury or conditions requiring immediate *diagnosis and treatment.*

*Emergency services* and care include ambulance, medical screening, exam and evaluation by a doctor or appropriate personnel. Emergency services include both physical and psychiatric emergency conditions.

Examples of emergencies include, but are not limited to:

- Hard to breathe
- Seizures (convulsions)
- Lots of bleeding
- Unconsciousness/blackouts (will not wake up)
- Severe pain (including chest pain)
- Swallowing of poison or medicine overdose
- Broken bones
- Head Injury
- Eye Injury

**WHAT TO DO IN AN EMERGENCY:**

**Call 911 or go to the nearest emergency room.** Emergency care is covered at all times and in all places.

**After you receive emergency care:**

**STEP 1**: Call **Community Health Plan** within 24 hours of receiving emergency care or as soon as possible.

**STEP 2**: Follow the instructions of the emergency room doctor.

**STEP 3**: Call your *PCP* to make an appointment for follow-up care.

**Unsure if you need emergency care?**

**STEP 1**: Call your *PCP* or **Community Health Plan**.

**STEP 2**: Tell them about your condition and follow their instructions.

**Do Not Use The Emergency Room For Routine Health Care Services.**

## ➲ How To Get Emergency Transportation

Call 911 if you believe you need an ambulance. If you are unsure, call your *PCP* and follow your *PCP's* advice.

**Do not call 911 for non-emergency problems. Community Health Plan** may refuse to pay if you use an ambulance for non-emergencies. Non-emergency problems may include, but not be limited to, the following: earaches, colds, flu, and sore throats. Ambulances for emergencies are paid for by **Community Health Plan**.

## ➲ How To Get Non-Emergency Transportation

Many health plans offer non-emergency transportation. This may include litter (stretcher) and wheelchair van services to and from appointments. Please call the doctor's office or **Community Health Plan** if you want help with transportation for your medical visits or for the Child Health and Disability Prevention (CHDP) office.

## How to Get Your Prescriptions Filled

**Community Health Plan** works with *pharmacies* in many neighborhoods. You must get your prescribed medications (drugs) from a *pharmacy* in **Community Health Plan's** *network*. A list of **Community Health Plan's** *pharmacies* can be found in your *provider directory,* which is included in your welcome packet.

## ➲ To Get Prescriptions Filled:

**STEP 1**: Choose a *pharmacy* that works with **Community Health Plan**.

**STEP 2**: Bring and show your *prescription* and your **L.A. Care/Community Health Plan** ID card to the pharmacist.

**You should not be asked to pay for your prescription drugs. Call Community Health Plan if the *pharmacy* asks you to pay.**

## ➲ What Drugs Are Covered

**Community Health Plan** uses a list of approved drugs called a *formulary*. Your doctor normally prescribes drugs from the *formulary*. Drugs are chosen for the *formulary* when they are:

- Food and Drug Administration (FDA) approved,
- Reviewed and approved by a committee of **Community Health Plan** *physicians* and pharmacists, on a quarterly basis.
- Generally accepted to be safe and effective, and
- Cost effective.

You may call **Community Health Plan** to request a copy of the *formulary*. Even though a drug may be on the *formulary*, your doctor may still not prescribe that drug based on your health status. You may also call **L.A. Care** for a list that compares all Plan Partner *formularies*.

**The Community Health Plan *formulary* allows you to get the following drugs when prescribed by your doctor and *medically necessary*:**

- *Prescription drugs* listed on the *formulary*.
- Non-*prescription drugs* or "over the counter" drugs (such as cough syrups, cough drops or aspirin) listed on the *formulary*.
- Diabetic supplies: Insulin, insulin syringes, glucose test strips, lancets and lancet puncture devices, inhaler extender devices, pen delivery systems such as EpiPens, and Ana-kits, blood glucose monitors including monitors for the visually impaired, ketone urine testing strips.
- FDA approved birth control and birth control devices, birth control pill, diaphragms, condoms, and contraceptive jellies).

### ➲ Drugs Not On The Formulary

Sometimes, your doctor may need to prescribe a drug that is not on the *formulary*. Your doctor must call to get *authorization* from **Community Health Plan.**

To decide if the non-formulary drug will be covered, **Community Health Plan** may ask your doctor and/or pharmacist for more information. **Community Health Plan** will reply to your doctor and/or pharmacist within 24 hours after receiving requested medical information.

Your doctor or pharmacist will let you know if the drug is approved. After approval, you can get the drug at a *pharmacy* in your *network*. If the drug is not approved, you have the right to appeal the decision. Go to the "Grievances and Appeals" Section on Pg.20 for more information.

## SUMMARY OF BENEFITS

Your *PCP* must arrange and *authorize* all your care before you receive services. All *health care services* are reviewed, approved or denied according to *medical necessity*. It is important that you learn about your benefits before you need them.

There are some services your *PCP* does not need to arrange or *authorize*. These services include:

- California Children Services (CCS)

- Child Health and Disability Prevention (CHDP)
- Confidential HIV testing
- Emergency services
- *Family planning* services
- Immunizations (Shots)
- Certain Obstetrical/Gynecological (OB/GYN) services, including pregnancy-related services. Call an OB/GYN doctor who is in the same *network* as your *PCP* to make an appointment. Go to OB/GYN on Pg.13 for more information.
- Native American Indians who receive health care from Indian Health Centers or a Native American Health Clinic. Go to the "Special Services for Native American Indians" Section on Pg.16 for more information.
- Sexually Transmitted Disease (STD) services
- Women, Infant and Children (WIC) services.

## Services

The services listed below are subject to all terms, conditions, limits, and exclusions described in this Member Handbook. This is not a complete list.

### ➲ Alcohol/Drug Abuse

Crisis services are covered. Call **Community Health Plan** for more information or for a referral**.**

### ➲ Cancer Screening

- All *generally medically accepted* cancer screening tests
- Mammography for screening or diagnostic purposes.
- Cervical Cancer Screening Test: if you are referred by your PCP or treating provider, you may get any other Cervical Cancer Screening test that is approved by the Food & Drug Administration (FDA) in addition to the usual Pap Smear Test.
- *Cancer Clinical Trial*s: if you have cancer, you may be able to be part of a *cancer clinical trial.* The cancer clinical trial must meet certain requirements, when referred by your **Community Health Plan** PCP or treating provider. The *cancer clinical trial* must have a meaningful potential to benefit you and must be approved by one of the following: the National Institute of Health (NIH), Food and Drug Administration (FDA), U.S. Department of Defense or the U.S. Veteran's Administration. If you are part of an approved *cancer clinical trial*, **Community Health Plan** will provide coverage for all *routine patient care cost* related to the *cancer clinical trial*.
- If you have a life threatening or debilitating condition or were eligible, but denied coverage for a *Cancer Clinical Trial,* you have the right to request an Independent Medical Review (IMR) on the denial. Go to page 21 section, "When to File an IMR."

### ➲ Confidential HIV Testing

You do not need prior *authorization* from your *PCP* for confidential HIV testing. You may receive confidential HIV testing from any health care

*provider* licensed to provide these services. Examples of where you can get confidential HIV testing include:

- Los Angeles County Department of Health Services
- *Family planning services providers*
- *PCP*
- Prenatal clinics

Please call **Community Health Plan** to request a list of testing sites.

## ➲ Diabetic Services

The following services are covered for diabetics when *medically necessary*:

- Equipment
- *Prescription* drugs
- Diabetes-related Supplies:
  - Blood glucose monitors and blood glucose testing strips.
  -Blood glucose monitors designed to assist the visually impaired for insulin dependent, non-insulin dependent and gestational diabetes.
  -Insulin pumps and all related necessary supplies.
  -Ketone urine testing strips.
  -Lancets and lancet puncture devices.
  -Pen delivery systems for the administration of insulin.
  -Podiatric devices to prevent or treat diabetes-related complications.
  -Insulin syringes.
  -Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.
- Training and education for self-management
- Family education for self-management

## ➲ Doctor Office Visits

All visits, exams, treatments, shots, and CHDP visits are provided by your *PCP*.

You may also get CHDP services from school-based programs or the Los Angeles County Department of Health Services. For more information, call CHDP at 1-323-890-7941.

## ➲ Drugs /Medications

*Prescription* drugs and over-the-counter drugs on the **Community Health Plan** formulary are covered. Go to the "How To Get Your Prescriptions Filled" Section on Pg.8 for more information.

## ➲ Durable Medical Equipment (DME)

DME is medical equipment that is used repeatedly by a person who is ill or injured. Examples include:

- Apnea monitors
- Blood glucose monitors, including monitors for the visually impaired for insulin dependent, non-insulin dependent and gestational diabetes
- Insulin pumps and all related supplies
- Nebulizer machines
- *Orthotics*
- Ostomy bags
- Oxygen and oxygen equipment
- *Prosthesis*
- Pulmo-Aides and related supplies
- Spacer devices for metered dose inhalers
- Tubing and related supplies

- Urinary catheters and related supplies

*Medically necessary* DME is provided when ordered by your *PCP*.

## ➲ Emergency Services*

Emergency care covers medically necessary emergency care services 24 hours a day, seven (7) days a week. Emergency care is a service that a "*prudent lay person"* considers necessary to stop or relieve sudden:

- Serious and unexpected illness
- Injury
- Conditions requiring immediate *diagnosis and treatment.*

*Emergency services* and care include ambulance, medical screening, exam and evaluation by a doctor or appropriate personnel. Emergency services include both physical and psychiatric emergency conditions.

## ➲ Family Planning

You may receive *family planning services* and FDA approved contraceptives from any health care *provider* licensed to provide these services. Examples of family planning *providers* include:

- Clinics
- Nurses/midwifes
- OB/GYN services (go to "OB/GYN" on pg. 18 for more information)
- *PCPs*
- Planned Parenthood locations

*Family planning services* also include counseling and surgical procedures for the termination of pregnancy (abortion). Please call **Community Health Plan**.

You have the right to receive *family planning services* and choose a doctor or clinic not with **Community Health Plan.** You do not need *authorization* from your *PCP*. A list of family planning clinics is available. Please call **Community Health Plan** to ask for a copy.

Some *hospitals* and other *providers* do not provide one or more of the following services that may be covered under your plan, and that you or your family member might need. These services may include one or more of the following:

- *Family planning services*;
- Contraceptive services, including emergency contraception;
- Sterilization, including tubal ligation at the time of labor and delivery; or
- Abortion

If you want more information before you *enroll*, call your doctor, *medical group*, independent practice association (IPA), or clinic. You can also call Community Health Plan to make sure that you can get the *health care services* that you need.

The *State Department of Health Services (SDHS)* Office of Family Planning can also answer any questions or give you a referral for *family planning services*. You may reach them at 1-800-942-1054.

## ➲ Health Education Services

You should receive health education from your PCP. Ask your PCP for health

education materials and available classes. You can also call **Community Health Plan**.

Health education services provide support to members to:

- Promote health
- Prevent diseases
- Help manage *chronic* diseases (such as asthma, heart disease, and diabetes)

Health education services are delivered through:

- Classes
- Counseling
- Support groups
- Diabetic self-management education programs which include nutrition and counseling. Go to Diabetic Services on pg. 11 for more information.

Ask your *PCP* for health education materials and classes. You can also call **Community Health Plan**.

## ➲ Hearing Aids

*Medically necessary* hearing aids are provided when ordered by your *PCP*.

## ➲ Home Health

*Medically necessary* home health services are provided when ordered by your *PCP*. These services are provided in the home by health care personnel. This includes visits by:

- Registered Nurses,
- Licensed Vocational Nurses, and
- home health aides
- short-term *physical, occupational and speech therapy* and
- *respiratory therapy* when prescribed by a licensed practitioner acting within the scope of his or her licensure.

Services are limited to those authorized by L.A. Care. If a service can be provided in more than one location, L.A. Care will work with the provider to choose the location.

**Exclusions**: Custodial care

## ➲ Hospice Care

*Medically necessary hospice* care is provided when ordered by your *PCP*.

## ➲ Hospital Care

*Medically necessary hospital* care is provided and includes, but is not limited to:

- *Inpatient* services
- Intensive care
- *Outpatient* services

## ➲ Interpreter Services

An interpreter is a person who translates orally what is said in one language to another language. This allows persons of different languages to speak with each other and understand each other.

Services in your language are available 24 hours a day, 7 days a week. Call **Community Health Plan, L.A. Care,** or your *PCP***.**

## ➲ Lab Services

These services (such as blood work, urine tests, and throat cultures) will be

provided when ordered by your doctor, at a *network*:

- Doctor's office
- *Hospital*
- Laboratory

## ➲ Mastectomy

Mastectomy is a surgery to remove a breast, due to cancer. After a mastectomy, **Community Health Plan** covers *prosthesis* and reconstructive surgery. Go to Reconstructive Surgery on Pg.14 for more information.

You and your doctor decide how long you need to stay in the *hospital* after the surgery, based on *medical necessity*.

## ➲ Maternity Care

Maternity care includes:

- Regular doctor visits during your pregnancy (prenatal)
- *Diagnostic* and genetic testing
- Nutrition counseling
- Labor and delivery care
- Health care 6 weeks after delivery (postpartum)

Call your doctor right away if you think you are pregnant. It is important to receive care right away and throughout your pregnancy.

You can choose your maternity care doctor from a doctor in your *network*. Ask your *PCP* for more information. You can also call **Community Health Plan**.

You have the right to stay in the *hospital* for at least 48 hours for a vaginal delivery. You have the right to stay in the *hospital* for at least 96 hours for a cesarean section.

After giving birth, you will receive breastfeeding education and special equipment, if needed. Ask your doctor, or call **Community Health Plan** if you have any questions**.**

Go to the "Women, Infants, and Children (WIC) Program" Section on Pg.15 for information about nutrition and food stamps.

## ➲ Newborn Care

Your new baby will be covered by **Community Health Plan** for the month of birth and the following month. To *enroll* your baby in *Medi-Cal*, contact your *eligibility worker* at DPSS toll-free at 1-877-481-1044.

A **Community Health Plan** doctor in your *network* should see your baby within the first 2 weeks of birth.

Newborn screenings for certain treatable genetic disorders are covered. These genetic disorders include:

- Phenylketonuria (PKU)
- Galactosemia
- Hypothyroidism
- Sickle cell disease
- Related blood disorders.

Babies with these conditions will be referred to California Children Services (CCS) for treatment or to **Community Health Plan** if the treatment is not covered by CCS. Treatment of PKU includes medically prescribed formulas and special food products. PKU cases

are followed by a health care professional who consults with a doctor specializing in PKU related diseases. Go to the "Special Services for Children" Section on Pg.16 for more information on CCS.

## ➲ Nurse/Midwife and Nurse Practitioner

You may receive services from a nurse/midwife or certified nurse practitioner who works in your *PCP's network*. You do not need prior *authorization*. For more information ask your *PCP* or call **Community Health Plan.**

## ➲ Health Information Privacy

At L.A. Care, **Community Health Plan,** we value the trust you have in us. We want to keep you as a L.A. Care**/Community Health Plan** member. That's why we want to share with you the steps L.A. Care/**Community Health Plan** takes to keep health information about you and your family private.

To keep health information about you and your family private, L.A. Care**/Community Health Plan:**

- Uses secure computer systems
- Handles health information the same way, every time
- Reviews the way L.A. Care**/Community Health Plan** handles health information
- Follows all laws about the privacy of health information

All L.A. Care/**Community Health Plan** staff who have access to your health information are trained on privacy laws. They also follow L.A. Care/**Community Health Plan** guidelines. They even sign a note that they will keep all health information private. L.A. Care**/Community Health Plan** does not give out health information to any person or group who does not have a right to it by law.

L.A. Care**/Community Health Plan** needs some information about you so that we can give you good health care services. This information includes:

- Name
- Gender
- Date of birth
- Language you speak
- Home address
- Home or work telephone number
- Occupation and employer
- Whether you are married or single
- Health history

L.A. Care/**Community Health Plan** may get this information from any of these sources:

- You
- A parent, guardian, or conservator
- Another health plan
- Your doctor
- Your application for the health care program
- Your health records

Before L.A. Care**/Community Health Plan** gives your health information to another person or group, we need your written approval. There are times when we may not get your written approval. This may happen when:

- A court, arbitrator, or similar agency needs your health information
- A subpoena or search warrant is requested
- A coroner needs your health information
- Your health information is needed by law

L.A. Care**/Community Health Plan** may give your health information to another health plan to:

- Make a diagnosis or treatment
- Make payment for your health care
- Review the quality of your health care

Sometimes, we may also give your health information to:

- groups who license health care providers
- public agencies
- investigators
- probate courts
- organ donation groups
- federal or state agencies as required by law
- disease management programs

Sometimes, L.A. Care**/Community Health Plan** may also give out some information from your employer about job performance. This information will help determine your health coverage or manage our health plan.

If you have any questions or would like to know more about your health information, please call L.A. Care Member Services.

## ➲ Obstetrical/Gynecological (OB/GYN)

You do not need prior *authorization* from your *PCP* or **Community Health Plan** to see an OB/GYN or family practitioner that works in your *network*. You may choose your OB/GYN to be your PCP and you may seek services directly from your OB/GYN. Please call **Community Health Plan** if you have any questions.

## ➲ Out of Service Area Coverage

The service area is the geographic area a health plan is licensed to provide health care services. Some plans do not serve all of Los Angeles County. Call **Community Health Plan** to ask about their service area. All locations outside of Los Angeles County are out of the service area. Only emergency and urgent services are covered out of service area. Routine care is not covered out of service area. Go to the "How To Get Urgent Care" on Pg.6 and "How To Get Emergency Care" Section on Pg.7 for more information.

## ➲ Prenatal Care

Go to Maternity Care on Pg.12 for more information.

## ➲ Reconstructive Surgery

Reconstructive surgery repairs abnormal body parts, improves body function, or brings back a normal look.

Reconstructive surgery is covered when *medically necessary*. Reconstructive surgery is provided, when requested by your *PCP* and *authorized* by **Community Health Plan.**

### ➲ Sexually Transmitted Disease (STD) Services

STD services include:

- Preventive care
- Screening
- Testing
- *Diagnosis*
- Counseling
- Treatment
- Follow-up

You may receive STD services from any doctor or clinic**.** You do not need prior *authorization* from your *PCP*.

### ➲ Skilled Nursing Facility

*Medically necessary* care in a *skilled nursing facility* is provided when ordered by your *PCP*. Go to the "Additional Disenrollments" Section on Pg.21 for more information.

### ➲ Therapy – Occupational, Physical and Speech

*Medically necessary occupational, physical, and speech therapy* are provided, when ordered by your *PCP* and *authorized* by **Community Health Plan**.

### ➲ Vision Care

For information about eye exams or vision care coverage call **Community Health Plan.**

Eye exams are covered by **Community Health Plan.** You are limited to one pair of eyeglasses every 2 years unless your *prescription* changes. This includes lenses and covered frames for eyeglasses when *authorized*.

### ➲ X-ray Services

These services will be provided when ordered by your doctor at a *network*:

- Doctor's office
- *Hospital*
- Laboratory

## CARVED OUT SERVICES

Carved out services are services that *members* may receive through the *Medi-Cal* program, but are not covered by **L.A. Care** or **Community Health Plan.** These services are available through regular (fee-for-service) *Medi-Cal* or other public programs. You may need to meet *eligibility* requirements to receive services. Please call **L.A. Care** or **Community Health Plan** if you have any questions.

- Acupuncture
- Adult day health care
- Alcohol and Drug Treatment Services (*outpatient*)
- California Children Services (CCS) *eligible* conditions
- Childhood lead poisoning (Los Angeles County Department of Health Services)
- Chiropractic services
- Direct Observed Therapy for the treatment of tuberculosis (Los Angeles County Department of Health Services)
- Dental services. **Community Health Plan** covers dental

screenings under the first health check-up and will refer *members* to *Medi-Cal* dental *providers*. **Community Health Plan** covers the following when *medically necessary*: *prescription* drugs, lab services, *outpatient* surgical services, and *inpatient* services. General anesthesia for dental work is covered for *members* under 7 years of age or developmentally *disabled*, or when *medically necessary.*

- Local Education Agency (LEA assessment services)
- Major organ transplants (Go to the "Additional Disenrollments" Section on Pg.21 for more information)
- *Mental health* services. Specialized *mental health* services are provided through the Los Angeles County Department of Mental Health (LACDMH). You may receive services from LACDMH with or without a referral from your *PCP*. LACDMH may be reached toll-free at 1-800-854-7771. Your *PCP* will treat *mental health* conditions within the scope of their training and practice. *Mental health* drugs listed on the formulary and prescribed by a licensed *mental health provider* are covered by **Community Health Plan,** or regular (fee-for-service) *Medi-Cal*. For *mental health* services provided by **Community Health Plan**, if medically necessary, you may also get a *mental health* drug not on the *formulary*. Go to a *network pharmacy* to fill out your *prescription.* Go to the "How To Fill Your Prescriptions" Section on Pg.8 for more information.
- Prayer or spiritual healing
- State laboratory services under the State Serum Alphafetoprotein Testing Program.
- Corrective lenses/eyeglasses (frames and lenses).

## NON-COVERED SERVICES

The following is a list of services not covered by **L.A. Care/Community Health Plan** or by the regular (fee-for-service) *Medi-Cal* program:

- All services excluded from *Medi-Cal* under state and federal law
- Circumcision
- Cosmetic Surgery
- *Experimental and investigational in nature* services (Go to the "EIR" Section on Pg.19 for more information)
- *Infertility*
- Immunizations (shots) for work/travel
- Personal comfort items, (such as phones, television and guest tray) when in the *hospital*
- Temporal Mandibular Joint (TMJ) disease. Unless medically necessary after examination.

If you have questions about what is covered, please call **Community Health Plan**.

## SPECIAL SERVICES

### Special Services for Children

#### ➲ California Children Services (CCS)

CCS is open to persons under the age of 21 with a *disability*. If your child has a *chronic* medical illness, he/she may be *eligible* for services under CCS. Talk to your child's *PCP* about CCS. CCS will work with a medical specialist to arrange for your child's care. If you are getting care from a CCS *provider*, you may continue getting services as a *member* of **L.A. Care/Community Health Plan.**

Please call **Community Health Plan** if your child is receiving CCS services. We can arrange for those services to continue. You may call the Los Angeles County CCS office toll-free at 1-800-288-4584 for more information.

#### ➲ Child Health and Disability Prevention (CHDP)

Your child may receive CHDP through your child's local school. If your child is receiving CHDP services when you join **L.A. Care/Community Health Plan,** please call **Community Health Plan** to arrange for those services to continue. You may call CHDP at 1-800-993-2437 (1-800-993-CHDP), if you have any questions.

### Women, Infants and Children (WIC) Program

The Women, Infants and Children (WIC) Supplemental Nutrition Program gives pregnant women, new mothers, and their babies nutrition information and food stamps. Ask your doctor or maternity nurse for more information about WIC. You may call WIC directly at 1-888-942-2229 or 1-888-WIC-Baby.

### Minor Consent Services

A minor may, without their parent's knowledge or consent, receive the following:

- Counseling and surgical procedures to end pregnancy (abortion)
- Drug and alcohol abuse services
- *Family planning services*
- *Outpatient mental health* treatment and counseling
- Pregnancy related services
- Sexual assault services
- Sexually Transmitted Disease (STD) services

### Special Services for Native American Indians

Native American Indians have the right to get *health care services* at Indian Health Centers and Native American Health Clinics. You do not need to *disenroll* from **L.A. Care/Community Health Plan** to get *health care services* from an Indian Health Center or Native American Health Clinic. You also may disenroll from **L.A. Care/Community Health Plan** at any time and for any reason. Go to the "Disenrollment" Section on Pg.21 for more information. Please call Indian Health Services at 1-916-930-3927 for more information. You may visit the Indian Health Services website at **www.ihs.gov** for more information.

## GRIEVANCES AND APPEALS

### Grievances

We want to know about any problems you may have in getting *health care services*. Have you had problems with any of the following?

- Your *medical group*
- Your doctor
- Your *hospital*
- **Community Health Plan**
- **L.A. Care**

Call the **Community Health Plan** *Member Services Department* if you have had problems. A Member Services Representative will make every effort to help you. If you are still not happy, you may use the **Community Health Plan** *grievance* process. This process lets us know that you are not satisfied. We want to hear your suggestions about how we can improve our services.

**L.A. Care/Community Health Plan** provides you with 2 levels of review for any *grievance* you have about your health care.

### ➲ First Level of Review (Community Health Plan)

**STEP 1:** When you have a *grievance* you may write, visit, or call **Community Health Plan** at:

**Community Health Plan**
Grievance Coordinator
1000 South Fremont Avenue
Building A-9 East, 2nd Floor, Unit #4
Alhambra, CA 91803
**1-800-475-5550**

Your *grievance* can be taken over the phone. You may call the **Community Health Plan** *Member Services Department* to have a form mailed to you.

**STEP 2:** After you have filled out the form, return the form to **Community Health Plan.** Please ask **Community Health Plan** if you need help filling out the form.

**STEP 3:** After **Community Health Plan** has received your *grievance,* you will receive a letter within 5 days informing you that **Community Health Plan** has received your *grievance.* The letter will include a contact person who you may call for information.

**Community Health Plan** will review your *grievance* and work to resolve your problem. **Community Health Plan** will send you a letter of how the *grievance* was resolved within 30 days from the day your *grievance* was received. The letter will include information on how to file an appeal with **Community Health Plan** or how to ask for a second level review with **L.A. Care.**

### ➲ Second Level of Review (L.A. Care Health Plan)

If you are not happy with **Community Health Plan's** decision on your *grievance*, you may write or call **L.A. Care. L.A. Care** will work with you and **Community Health Plan** to resolve the *grievance*. After **L.A. Care** has received your *grievance,* you will receive a letter within 5 days informing you that **L.A. Care** has received your *grievance.* Your *grievance* will be resolved within 30 days from the day your *grievance* was received.

**EXPEDITED APPEAL (Urgent review of denied services)**
In urgent cases where services were denied, you can request an expedited appeal. An expedited appeal is an urgent review of denied services. You will receive a call and/or a letter within 24 hours. The decision will be made by **Community Health Plan (first level of review)** or **L.A. Care (second level of review)** within 3 days from the day your *grievance* was received.

Examples of urgent cases include:

- Severe pain
- Potential loss of life, limb or major bodily function
- Immediate and serious deterioration of your health

## Department of Managed Health Care (DMHC)

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. DMHC has a toll-free number **1-888-HMO-2219 (1-888-466-2219)** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (**1-800-735-2929 (TTY)** or **1-888-877-5378 (TTY)** to contact DMHC. DMHC's Internet website (**http://www.hmohelp.ca.gov**) has complaint forms and instructions online. If you have a grievance against your health plan, you should first call **Community Health Plan** or **L.A. Care** and use the plan's grievance process before contacting DMHC. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call DMHC for assistance. The plan's grievance process and DMHC's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

**!** **L.A. Care Health Plan/Community Health Plan does not handle *grievances* about your *Medi-Cal eligibility*. For these types of questions, call your DPSS *eligibility worker* toll-free at 1-877-481-1044.**

## Independent Medical Review of Grievances

The Independent Medical Review (IMR) is another appeal process that you may use when:

- **L.A. Care/Community Health Plan** made a decision that a *health care service* is not medically necessary, and
- you believe that all or part of that *health care service* has been wrongly denied, changed or delayed.

This is known as a *disputed healthcare service*.

You may still request a State Fair Hearing if you request an IMR. However, you will not be able to use the IMR process if you have requested a State Fair Hearing. Go to the "State Fair Hearing" Section on Pg.20 for more information.

The IMR is filed with DMHC. You have up to 6 months from the date of denial to file an IMR. You will receive information on how to file an IMR with your denial letter. You may reach DMHC at toll-free 1-888-HMO-2219 or 1-888-466-2219.

There are no fees for an IMR. You have the right to provide information to support your request for an IMR. After the IMR application is submitted a decision not to take part in the IMR process may cause you to forfeit certain legal rights to pursue legal action against the plan.

## ➲ When To File An IMR

! You may file an IMR if you meet the following requirements:

1.a) Your doctor says you need a health care service because it is *medically necessary* and it is denied; or

b) You received urgent or emergency services determined to be necessary and it was denied; or

c) You have seen a *network* doctor or PCP for the *diagnosis* or treatment of the medical condition **(even if the health care service was not recommended by a network provider)**;

2. The *disputed health care service* is denied, changed or delayed by **L.A. Care/Community Health Plan** based in whole or in part on a decision that the *health care service* is not *medically necessary*, and

3. You have filed a grievance with **L.A. Care/Community Health Plan** and the *health care service* is still denied, changed, delayed or the grievance remains unresolved after 30 days.

You must first go through the **L.A. Care/Community Health Plan** *grievance* process, before applying for an IMR.

You have up to 6 months from the date of denial to file an IMR.

The dispute will be submitted to a DMHC medical specialist if it is *eligible* for an IMR. The specialist will make an independent decision of whether or not the care is *medically necessary*. You will receive a copy of the IMR decision from DMHC. If it is decided that the service is *medically necessary*, **L.A. Care/Community Health Plan** will provide the *health care service*.

**NON-URGENT CASES**
For non-urgent cases, the IMR decision must be made within 30 days. The 30 day period starts when your application and all documents are received.

**URGENT CASES**
If your *grievance* is urgent and requires fast review, you may bring it to DMHC's attention right away. You will not be required to participate in the **L.A. Care/Community Health Plan** *grievance* process for more than 3 days.

For urgent cases the IMR decision must be made within 3 business days from the time your information is received. Examples of urgent cases include:

- Severe pain
- Potential loss of life, limb, or major bodily function

- Immediate and serious deterioration of your health

## ➲ External Independent Review (EIR)

You can request an EIR through DMHC when a medical service, drug or equipment is denied because it is *experimental or investigational in nature*. You have up to 6 months from the date of denial to file an EIR. You may provide information to the EIR panel. The EIR panel will give you a written decision within 30 days from when your request was received. In urgent cases the EIR panel will give you a decision within 3 business days from the time your information is received.

**!** You may file an EIR if you meet the following requirements:

1. You have a very serious condition that is "*life-threatening*" or "*debilitating*" (for example, terminal cancer).
2. Your doctor must certify that:
   - the standard treatments were not or will not be effective or
   - the standard treatments were not medically appropriate, or
   - the proposed treatment will be the most effective.
3. Your doctor will certify in writing that the drug, equipment, procedure, or the requested therapy is likely to work better than standard treatment.
4. You have been denied a drug, equipment, procedure, or other therapy requested by your doctor.
5. Your doctor certified in writing, based on certain medical and scientific evidence that, the requested treatment is likely to be more beneficial for you than any standard treatment.
6. The treatment would have been covered as a benefit, call Community Health Plan has determined that it is *experimental and investigational*.

For more information or help with the IMR or EIR process or to request an application form, please call **Community Health Plan**.

## State Fair Hearing

A State Fair Hearing is another way you can file a *grievance*. You can present your case directly to the State of California. All **L.A. Care/Community Health Plan** *members* have the right to ask for a State Fair Hearing at any time within 90 days of the incident. You may still request a State Fair Hearing if you request an IMR. However, you will not be able to use the IMR process if you have requested a State Fair Hearing. Go to the "IMR" Section on Pg.18 for more information.

You may ask for a State Fair Hearing by calling toll-free 1-800-952-5253 (English and Spanish), or by writing to:

**California Department of Social Services**
**Administrative Adjudication Division**
**744 P Street, Mail Station 19-3733**
**Sacramento, CA 95814**

You can also call the DPSS Los Angeles County office toll-free at 1-877-481-1044. If you do not speak English, please stay on the line and ask for the language you speak. DPSS has staff who speak Armenian, Chinese, Russian,

Spanish, Tagalog, and Vietnamese. You may also write to:

**Department of Public Social Services (DPSS)**
**State Fair Hearings Section**
**P.O. Box 10280**
**Glendale, CA 91209**

**Ombudsman Office**
You may also call the Ombudsman office of the *State Department of Health Services (SDHS)* for help with *grievances*. Call toll-free 1-888-452-8609.

# DISENROLLMENTS

## Mandatory Medi-Cal Managed Care Members

In Los Angeles County, most people with *Medi-Cal* are required by *SDHS* to *enroll* in a health plan. Those who are required to *enroll* in a health plan are called mandatory *members*. A mandatory *member* may *disenroll* from *Medi-Cal* managed care only if:

- The *member* has a complex medical condition (such as HIV/AIDS or cancer),
- The *member* has been in *Medi-Cal* managed care less than 90 days, and
- The *member* is being treated by a doctor who does not work with any *Medi-Cal* managed care health plan.

Otherwise, the *member* must choose a plan.

## Voluntary Medi-Cal Managed Care Members

In Los Angeles County, some people with *Medi-Cal* may choose to enroll in a health plan. Those who choose to enroll in a health plan are called voluntary *members*. A voluntary *member* may choose to leave their health plan and return to regular (fee-for-service) *Medi-Cal* at any time. These *members* include the following:

- The disabled or elderly receiving Supplemental Security Income (SSI)
- Those 65 years or older
- Native American Indians and their household, and others who are *eligible* to get services from an Indian Health Center or Native American Health Clinic
- Children in foster care or the Adoption Assistance Program

To *disenroll* from **L.A. Care**, call Health Care Options (HCO) at 1-800-430-4263. HCO is the agency who *enrolls* or *disenrolls Medi-Cal* beneficiaries in or out of a managed care *Medi-Cal* health plan. They will send you a *disenrollment* form. Your membership will end on the last day of the month in which HCO approves your request. *Disenrollment* takes about 15 to 45 days. You must continue to receive services through **Community Health Plan** until you are *disenrolled* from **L.A. Care/Community Health Plan**.

## Additional Disenrollments

Managed care coverage, under **L.A. Care**, for mandatory and voluntary *members* will end if any of the following has occurred:

- You move out of Los Angeles County permanently
- You are in a long-term care or intermediate care facility beyond the month of admission and the following month
- You require medical *health care services* not provided by **Community Health Plan** (for example, some major organ transplants, and *chronic* kidney dialysis)
- You have other non-government or government sponsored health coverage
- You are *incarcerated*

## Involuntary Disenrollments

Mandatory and voluntary *members* can be *involuntarily disenrolled* from **L.A. Care/Community Health Plan** if:

- A member takes part in any fraud having to do with services, benefits, or facilities of the plan.
- A member shows an ongoing significant disruptive behavior towards other members, providers, provider staff, or **Community Health Plan**.
- If **Community Health Plan** is not able, in good cause, to give health care services to members without significant harship.

If you are *disenrolled* from **L.A. Care**/**Community Health Plan**, we will send you a letter that says when your coverage will end and why. You may file an appeal with **Community Health Plan** or **L.A. Care**. Go to the "Grievances and Appeals" Section on Pg.17 for more information. You may also ask for a review from DMHC and *SDHS*. Call **L.A. Care** for more information.

# PARTICIPATING IN PUBLIC POLICY MEETINGS

Many of the **L.A. Care/Community Health Plan** policies are decided by *SDHS*. Other policies are set by **L.A. Care/Community Health Plan** and *members* like you.

## Community Health Plan Public Policy Committee

**Community Health Plan** has a public policy committee that you may join. This committee discusses *member* and health plan issues. For more information, please call **Community Health Plan.**

## L.A. Care Regional Community Advisory Committees (RCAC)

There are 11 **L.A. Care** Regional Community Advisory Committees (RCACs) in Los Angeles County. RCAC is pronounced "rack." The RCAC's purpose is to:

- Talk about *member* issues and concerns, and resolve them through the *Member Services Department*
- Advise the L.A. Care Board of Governors
- Educate and empower the community on health care issues

The RCACs meet once a month. The RCACs include **L.A. Care** *members*,

*member* advocates (supporters), and health care *providers*. For more information about RCACs, call the **L.A. Care** Community Outreach and Education Department toll-free at 1-888-522-2732.

## Board of Governors Meetings

The Board of Governors decides policies for **L.A. Care**. Anyone can attend the meetings. The Board of Governors meets on the first Thursday of each month from 2:00 p.m. to 4:00 p.m. For more information call the **L.A. Care** Meeting Information Line at 1-213-438-5408**.**

## Communicating Policy Changes

You will get information on all policy changes that affect your health care. It will be included in your *member* newsletter or special mailings.

# OTHER INFORMATION

## If You Move

When you move it is important to call the following people:

- Call your *eligibility worker* at DPSS right away so that you remain *eligible* for *Medi-Cal*. Your *eligibility worker's* phone number is toll-free 1-877-481-1044. You must live in Los Angeles County to receive *Medi-Cal benefits* from **L.A. Care**.
- Call **Community Health Plan.** You will need to update your information (address and phone number). This allows **Community Health Plan** to send you your ID Card and important information about your health care *benefits*.

## If You Get a Bill

**Community Health Plan** pays for all covered medical costs approved by your *PCP* or for an emergency. You should not receive a bill for any services covered by **Community Health Plan.** Please call **Community Health Plan** if you receive a bill for medical services.

## If You Have Other Insurance

If you have any health insurance other than **L.A. Care/Community Health Plan**, it is important to let us know. Please call **Community Health Plan** if you have any questions. We will send all bills to the correct place for payment.

## How A Provider Gets Paid

Health care *providers* are paid in one of two ways:

- A fee for each service provided
- Capitation - a flat rate paid each month per *member*

Please call **Community Health Plan** if you would like to know more about how your doctor is paid, or about financial incentives or bonuses.

## Third Party Liability

Community Health Plan will provide *covered services* where an injury or illness is caused by a third party. The term "third parties" include insurance companies, individuals, or government agencies.

Under California State Law, **Community Health Plan** may assert a *lien* on any payment or right to payment which you have or may have received as a result of a third party injury or illness. The amount of this *lien* may include:

- Reasonable and true costs paid for *health care services* given to you, and
- An additional amount as provided under California State Law.

As a member, you also agree to assist Community Health Plan in recovering payments for services provided. This may require you to sign or provide documents needed to protect the rights of **Community Health Plan**.

## Transitional Medi-Cal

Transitional *Medi-Cal* (TMC) is also called "*Medi-Cal* for working people." If you stop getting *Medi-Cal* for one of these reasons you may be able to get TMC:

- You started earning more money, or
- Your family starts receiving more child or spousal support.

For example, if you are the person in your household who earns the most money, you might get TMC. Also, if one of the two things above has happened to you, but you are a caretaker relative, you might get TMC.

Parents and caretaker relatives who get TMC can get free *Medi-Cal* coverage for 6 to 24 months. If you have stopped getting *Medi-Cal*, you should ask your *eligibility worker* if you qualify for TMC. Call your *eligibility worker* at DPSS, toll-free at 1-877-481-1044, right away. You can stay with **L.A. Care/Community Health Plan** if you are *eligible* for TMC.

## Organ Donation

There is a need for organ donors in the United States. You can agree to donate your organs in the event of your death. The California Department of Motor Vehicles (DMV) will give you a donor card if you wish to become an organ or tissue donor. The DMV will also give you a donor sticker to place on your driver's license or I.D. card.

## What is an Advance Directive?

An advance directive is a signed legal document. It allows you to select a person to make your health care choices at a time when you cannot make them yourself (such as, if you are in a coma). An advance directive must be signed when you are able to make your own decisions. Ask your *PCP* or call **Community Health Plan** for more information about advance directives.

# OTHER SERVICES

***(This section is reserved for the Plan Partner.)***

## ARBITRATION OF DISAGREEMENTS

**PLEASE READ THIS SECTION CAREFULLY!**

**L.A. Care/Community Health Plan** knows that some *members* wish to get *health care services* from a health plan that lets them settle problems through binding arbitration. Binding arbitration is a way to settle problems between you and your doctor or health plan without going to court. Many view binding arbitration as cheaper, quicker and better than the courts.

Other *members* believe that the court system is the best way to settle problems and do not wish to give up their right to have their problem settled by a judge or jury. Binding arbitration requires *members* to have all problems settled by neutral arbitration. This requires *members* to give up their right to a jury or a trial in court.

**Kaiser Permanente** is the only **L.A. Care** Plan Partner that requires binding arbitration to settle all problems, including claims of medical malpractice.

## GLOSSARY

This glossary will help you understand words used in this Member Handbook.

**Acute** is a word used for a serious and sudden condition that lasts a short time, and is not *chronic*. Examples include a heart attack, pneumonia, or appendicitis.

**Appropriately qualified healthcare professional** is an individual who has the training and expertise to treat or review the member's specific medical condition.

**Authorize/Authorization** is when a health plan approves treatment for covered *health care services*. *Members* must pay for non-approved treatment.

**Benefits** are the *health care services*, supplies, drugs, and equipment that are *medically necessary* and covered by *Medi-Cal*.

**Cancer Clinical Trial** is a research study with cancer patients to find out if a new cancer treatment or drug is safe and treats a member's type of cancer.

**Chronic** is a word used for a condition that is longterm and ongoing, and is not *acute*. Examples include diabetes, asthma, allergies, and hypertension.

**Diagnostic/Diagnosis** is when a doctor identifies a condition, illness or disease.

**Disability** is a physical or mental problem that totally or seriously limits one or more major life activity. (Disabled, Disabling)

**Disenroll/Disenrollment** is when a *member* leaves a health plan.

**Disputed health care service** is when a member questions a decision made by a health plan about a *health care service*.

**Eligible/Eligibility** means that a person meets certain requirements to receive *benefits* from programs such as *Medi-Cal*, California Children Services (CCS), and Child Health Disability Program (CHDP).

**Eligibility worker** is the person who determines *Medi-Cal eligibility*. This person works for the Department of Public and Social Services (DPSS).

**Enroll/Enrollment** is when a *member* joins a health plan.

**Experimental or investigational in nature** refers to new medical treatment that is still being tested, but has not been proven to treat a condition.

**Family planning services** help people learn about and plan the number and spacing of children they want, through the use of birth control.

**Formulary** is a list of approved drugs that is generally accepted in the medical community as safe and effective.

**Generally medically accepted** is a term used for tests or treatments that are commonly used by doctors for the treatment of a disease or *diagnosis*.

**Grievance** is the process used when a *member* is not happy with his/her health care. *Grievances* are about services of care received or not received. Sometimes called a complaint.

**Health care services** prevent and treat disease, and keep people healthy. Examples include some of the following:

- Doctor services (includes one-on-one visits with a doctor and referrals)
- Emergency services (includes ambulance and out-of-area coverage)
- Home health services
- *Hospital inpatient* and *outpatient* services
- Laboratory services
- *Pharmacy* services
- Preventive health services
- Radiology services

**Hospice** is the care and services provided to people who have received a *diagnosis* for a terminal illness. These services are given in a home or facility to relieve pain and provide support.

**Hospital** provides *inpatient* and *outpatient* care from doctors or nurses.

**Incarcerated** is when a person is ordered by law to be placed in jail, prison or a mental institution.

**Infertility** is when a person is not able to conceive and produce children after having unprotected sex on a regular basis for more than 12 months.

**Inpatient** is when a person receives medical treatment in a *hospital* or other health care facility with an overnight stay.

**Involuntary/Involuntarily** is when something is done without choice.

**Liable/Liability** is the responsibility of a party or person according to law.

**Life-threatening** is a disease, illness or condition that may put a person's life in danger if it is not treated.

**Medi-Cal** is a California State health coverage program for low-income families. This program is funded by state and federal dollars.

**Medical group** is a group of *PCPs*, specialists, and other health care *providers* that work together.

**Medically necessary/Medical necessity** refers to services provided to treat an illness or injury according to established and accepted medical practice standards.

**Member** is a person who has joined a health plan.

**Member Services Department** is the health plan's department that helps *members* with questions and concerns.

**Mental health** services are given for the *diagnosis* or treatment of a mental or emotional illness.

**Network** is a team of health care *providers* contracted with a health plan to provide services. The health care *providers* may be contracted directly with the health plan or through a *medical group*.

**Occupational therapy** is used to improve and maintain a patient's daily living skills, because of a *disability* or injury.

**Orthotic** is used to support, align, correct, or improve the function of movable body parts.

**Outpatient** is when a person receives medical treatment in a *hospital* or other health care facility without an overnight stay.

**Pharmacy** is a place to get prescribed drugs.

**Phenylketonuria (PKU)** is a rare disease. PKU can cause mental retardation and other neurological problems if treatment is not started within the first few weeks of life.

**Physical therapy** uses exercise to improve and maintain a patient's ability to function after an illness or injury.

**Physician** is a licensed medical doctor.

**Prescription** is a written order given by a licensed *provider* for drugs and equipment.

**Primary Care Physician (PCP)** is a personal doctor. The *PCP* takes care of health care needs and works with *members* to keep them healthy. The *PCP* will also make specialty referrals when *medically necessary*.

**Prosthesis** is used to replace a missing part of the body.

**Providers** are contracted with a health plan to provide covered *health care services*. Examples include:

- Doctors
- *Hospitals*
- *Skilled nursing facilities*
- Home health agencies
- *Pharmacies*
- Laboratories
- X-ray facilities
- Durable medical equipment suppliers

**Provider directory** is a list of *providers* contracted with a health plan for covered *health care services*. The list includes *PCPs*, h*ospitals, skilled nursing facilities,* urgent care, *pharmacies*, and vision care *providers.*

**Prudent Lay person** is an individual who does not belong to a particular profession or specialty, but has awareness or information.

**Routine patient care cost** is ordinary or normal costs for patient health care services.

**Seriously debilitating** is a disease, illness, or condition that if not stopped or changed, may cause death.

**Skilled nursing facility** is a facility licensed to provide medical services for non-*acute* conditions.

**Speech therapy** is used to treat speech problems.

**State Department of Health Services (SDHS)** is the California State agency that is responsible for the *Medi-Cal* program.

# IMPORTANT PHONE NUMBERS

## Disability Services

| | |
|---|---|
| Americans Disabilities Act Coordinator | 1-916-324-4695 |
| Hearing Impaired/California Relay Service (TTY) | 1-800-735-2929 |

## Children Services

| | |
|---|---|
| California Children Services (CCS) | 1-800-288-4584 |
| Child Health and Disability Prevention (CHDP) | 1-800-993-2437<br>(1-800-993-CHDP) |

## California State Services

| | |
|---|---|
| State Department of Health Services (SDHS) | 1-916-445-4171 |
| SDHS Ombudsman Office | 1-888-452-8609 |
| Department of Social Services | 1-800-952-5253 |
| Department of Managed Health Care (DMHC) | 1-888-466-2219<br>(1-888-HMO-2219) |

Health Care Options:

| | | | |
|---|---|---|---|
| English | 1-800-430-4263 | Hmong | 1-800-430-2002 |
| Armenian | 1-800-840-5032 | Lao | 1-800-430-4091 |
| Cambodian | 1-800-430-5005 | Russian | 1-800-430-7007 |
| Cantonese | 1-800-430-6006 | Spanish | 1-800-430-3003 |
| Farsi | 1-800-840-5034 | Vietnamese | 1-800-430-8008 |

| | |
|---|---|
| Supplemental Social Income (SSI) | 1-800-772-1213 |

## Los Angeles County Services

| | |
|---|---|
| Department of Public and Social Services (DPSS)<br>Central Help Desk (includes language services) | 1-877-481-1044 |

DPSS Public Charge Information Lines:

| | | | |
|---|---|---|---|
| Armenian | 1-800-453-6968 | Korean | 1-800-557-5351 |
| Cambodian | 1-800-632-9690 | Russian | 1-800-808-4044 |
| Chinese | 1-800-557-3731 | Spanish | 1-800-576-1519 |
| English | 1-800-815-5005 | Tagalog | 1-800-810-8985 |
| Farsi | 1-800-807-3938 | Vietnamese | 1-800-578-6762 |

| | |
|---|---|
| Los Angeles County Department of Health Services | 1-213-250-8055 |
| Los Angeles County Department of Mental Health | 1-800-854-7771 |
| Women, Infant, and Children (WIC) Program | 1-888-942-2229<br>(1-888-WIC-Baby) |
| L.A. Care Fraud and Abuse Hotline | 1-800-400-4889 |